MEDICARE MENTAL HEALTH

The Hyperlink Table, at the end of this document, gives the complete URL for each hyperlink.

Table of Contents

This booklet gives the following Medicare mental health services information:

- Covered and non-covered mental health services
- Eligible professionals
- Eligible professionals commonly used Current Procedural Terminology (CPT) codes
- National Correct Coding Initiative (NCCI)
- Provider charts
- Assignment
- Outpatient psychiatric hospital services
- Partial Hospitalization Program (PHP)
- Community Mental Health Centers (CMHC)
- Behavioral Health Integration (BHI) services
- Inpatient Psychiatric Facility (IPF) services
- Medical records requirements
- Coverage period
- Same day billing guidelines

COVERED MEDICARE MENTAL HEALTH SERVICES (FEE-FOR-SERVICE)

Medicare may cover these services to support behavioral health and wellness:

- Alcohol misuse screening and counseling (screening once per year for adults who use alcohol but do not meet the criteria for dependency; if misuse is detected, Medicare covers up to four brief face-to-face counseling sessions per year if the patient is alert and competent during counseling)
- Alcohol treatment, detoxification, and rehabilitative services including inpatient hospital stays
- Advance care planning (to discuss the patient's health care wishes if they are unable to make decisions about their care), as part of the Annual Wellness Visit, or as a separate Part B service
- Alcoholism outpatient hospital treatment services

Opioid Treatment Programs

As of January 1, 2020, CMS will pay certified Opioid Treatment Programs (OTPs) through bundled payments for opioid use disorder (OUD) treatment services under Medicare Part B. Covered services include FDA-approved opioid agonist and antagonist medication assisted treatment medications and their administration (if applicable), substance use counseling, individual and group therapy, toxicology testing, intake, and periodic assessments.

A list of OTP providers is available here: https://dpt2.samhsa.gov/treatment/directory.aspx.

- Annual Wellness Visit (AWV) (to develop or update a personalized prevention plan including a health risk assessment and a depression screen)
- Behavioral Health Integration (assessment, monitoring and care planning by clinical staff)
- Biofeedback therapy (non-drug treatment where patients learn to control bodily responses, such as heart rate and muscle tension)
- Bundled Payments for Opioid Use Disorder (OUD) (a bundled payment for the management and counseling for OUD billed in the office setting that includes overall management, care coordination, individual and group psychotherapy, and substance use counseling; for billing codes, refer to HCPCS G2086–G82088)
- Caregiver-focused health risk assessment helps the caregiver look at their own behavior and health risks (for the benefit of the Medicare patient)
- Chemical and electrical aversion therapy (therapy developed to condition a person to avoid undesirable behavior by pairing the behavior with unwanted stimuli)
- Cognitive Assessment and Care Planning (comprehensive evaluation of a new or existing patient who exhibits signs and/or symptoms of cognitive impairment, required to establish or confirm a diagnosis, etiology and severity for the condition)
- Chronic Care Management and Complex Chronic Care Management (for patients with multiple chronic conditions that place the person at high risk)
- Depression Screening (annual screening up to 15 minutes when staff-assisted depression care supports can assure accurate diagnosis, effective treatment, and follow-up at minimum supports consist of clinical staff in the primary care setting who can advise the physician of screening results and coordinate referrals to treatment)
- Diagnostic psychological and neuropsychological tests
- Drug therapy or pharmacological management (using medication[s] to treat disease); Medicare prescription drug plan sponsors have at-risk patient drug-management programs
- Drug withdrawal treatments (to treat signs and symptoms from removal of, or a decrease in, the regular dosage of a drug)
- Electroconvulsive therapy (depression and other mental illness treatment using electric current to the head)

- Family psychotherapy (with the patient present and their treatment is the primary purpose) or (without the patient present, is medically reasonable and necessary, and their treatment is the primary purpose)
- Health and behavioral assessment and/or intervention (to identify or treat the psychological, behavior, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health issues)
- Hypnotherapy (using an altered state of awareness to treat psychological or physical issues)
- Individual and group psychotherapy (individual therapy with one or more therapists and more than one individual in a therapy session with one or more therapists)
- Individual activity therapy as part of a partial hospitalization program (cognitive, physical, social and/or spiritual and not primarily recreational or diversionary)
- Initial Preventive Physical Examination (IPPE) (a review of medical and social health history and preventive services education)
- Interactive psychotherapy (where certain communication issues may interfere with treatment)
- Medication management (when a patient agrees on a medication treatment option for a trial period and is monitored for its effectiveness)
- Medication-Assisted Treatment (MAT) (uses medications with counseling and behavioral therapy to treat substance use disorders including opioid use disorders)
- Narcosynthesis (a form of narcoanalysis where the patient recalls repressed memories under hypnosis)
- Opioid Treatment Program (OTP) – beginning January 2020, Medicare will pay for certain medications and services furnished by certified OTP providers to treat opioid use disorders
- Partial hospitalization (a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care provided during the day that doesn't require an overnight stay, provided through a hospital outpatient department or community mental health center)
- Psychiatric Collaborative Care Services (an approach to behavioral health integration that enhances primary care services and includes a psychiatric consultant)
- Psychoanalysis (therapy that treats mental disorders by investigating the interaction of conscious and unconscious elements)
- Psychiatric evaluation (a systematic evaluation of the causes, symptoms, and the course and consequences of a psychiatric disorder)
- Screening, brief intervention, and referral to treatment services ("SBIRT") (early intervention for individuals with non-dependent substance use to help before the person needs more extensive or specialized treatment)
- Substance use disorder treatment through telehealth (a patient's home is now a permissible originating telehealth services site for substance use treatment, or a co-occurring mental disorder)
- Tobacco use cessation counseling
- Therapeutic activities like occupational therapy, recreational therapy, and milieu therapies (psychotherapy where there is control of the patient's social environment to prevent self-destructive behavior), if it is expected the therapeutic activities will improve the patient's condition

- Transitional care management (to furnish, within 30 days of discharge from an inpatient hospital setting, interactive contact, certain non-face-to-face services, and face-to-face visit)
- Urgently needed care (to treat a sudden illness or injury that isn't a medical emergency requiring immediate medical attention to prevent a disability or death)

PRESCRIPTION DRUG COVERAGE

Medicare Part D covers prescription drug benefits. Medicare Parts A and Part B do not cover drugs, although Medicare Part B covers some medications the patient cannot self-administer, such as injected drugs. For other prescription coverage, patients must enroll in a separate Medicare Part D prescription drug plan. Medicare Advantage enrollees can get Part A, Part B, and Part D drug coverage benefits under a single plan.

There are certain Medicare Part D protected mental health treatment drug classes, including antipsychotic drugs, antidepressant drugs, and anticonvulsant drugs. Medicare Part D prescription drug plans must cover most medications in these drug classes, with some exceptions.

MEDICARE ADVANTAGE ORGANIZATIONS

Medicare Advantage plans may offer supplemental benefits that are not covered under Medicare Parts A or B, if they diagnose, compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization. These types of benefits can address social determinants of health for patients with chronic illness.

For example, patients enrolled in a Medicare Advantage plan could receive social needs benefits, complementary therapies, services supporting self-direction, general supports for living (housing supports), support for caregivers, and food and produce in order to improve their health or overall function as it relates to their chronic illness. Plans determine which chronically ill patients are eligible for a particular item or service that the plan has elected to make available.

NON-COVERED MEDICARE MENTAL HEALTH SERVICES (FEE-FOR-SERVICE)

Medicare **does not** cover the following mental health services:

- Environmental intervention or modifications
- Adult day health programs
- Biofeedback training (any modality)
- Marriage counseling
- Pastoral counseling
- Report preparation
- Results or data interpretation or explanation
- Schizophrenia hemodialysis treatment
- Transportation or meals
- Phone services, or “apps”

ELIGIBLE PROFESSIONALS

Medicare recognizes the following Part B providers as eligible to furnish diagnostic and/or behavioral health treatment.

Medicare authorizes most of these providers to furnish Structured Assessment, Brief Intervention, and Referral to Treatment (SBIRT) services, as permitted under State law:

- Physicians (medical doctors [MDs] and doctors of osteopathy [DOs]), particularly psychiatrists
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- Clinical nurse specialists (CNSs)
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Certified nurse-midwives (CNMs)
- Independently Practicing Psychologists (IPPs)

PROVIDER CHARTS

These charts give individual provider-type required qualifications, coverage, and payment criteria information.

Psychiatrist

Required Qualifications	Coverage	Payment
You must meet the following qualifications: • MD or DO • Act within the scope of your license	The following coverage criteria apply: • Legally authorized to practice medicine in the State where you furnish services • Medicare does not statutorily preclude the services, and they are reasonable and necessary • You may furnish the general supervision assigned to diagnostic psychological and neuropsychological tests • You may give services and supplies “incident to” your professional services	The following payment criteria apply: • Paid at 100% under the Medicare Physician Fee Schedule (PFS)

Clinical Psychologist (CP)

Required Qualifications	Coverage	Payment

You must meet the following qualifications:
• Psychology Doctoral degree
• Licensed or certified in the State where you practice at the independent level and directly furnish diagnostic, assessment, preventive, and therapeutic services to patients
	The following coverage criteria apply:
	• Legally authorized to practice medicine in the State where you furnish services
	• Medicare does not statutorily preclude the services, and they are reasonable and necessary
	• If the patient consents, you must attempt to consult their attending or primary care physician about the services furnished and either:
	  ◦ Document the consent or declination date to consultations and the date of consultations in the patient's medical record
	  ◦ If consultations are unsuccessful, document the patient's medical chart with the date and manner of notification to the physician (does not apply if the physician referred the patient to the CP)
	• You may furnish the general supervision assigned to diagnostic psychological and neuropsychological tests
	• You may give services and supplies "incident to" your professional services, except for services furnished to hospital patients
		The following payment guidelines apply:
		• Paid only on an assignment basis
		• Paid at 100% of assigned services under the Medicare PFS

Clinical Social Worker (CSW)

Required Qualifications	Coverage	Payment
You must meet the following qualifications: • Social Work Master's or Doctoral degree • At least 2 years of supervised clinical social work • Licensed or certified as a CSW by the State where you furnish services • If you practice in a State that does not have licensure or certification, and you complete at least 2 years or 3,000 supervised social work practice clinical hours, post-Master's degree in an appropriate setting (for example, a hospital, Skilled Nursing Facility [SNF], or clinic)	The following coverage criteria apply: • Legally authorized to practice medicine in the State where you furnish services • Medicare does not statutorily preclude the services, and they are reasonable and necessary • You furnish services to diagnose and treat mental illnesses • Medicare does not pay for CSW services furnished to hospitalized patients with no CSW services coverage • Medicare covers hospital outpatient CSW services and pays under the CSW benefit when billed by the hospital to a Medicare Administrative Contractor under the CSW's National Provider Identifier • Medicare does not cover CSW services furnished to patients under a PHP furnished by a hospital outpatient department or Community Mental Health Center under the CSW benefit • Medicare does not cover CSW services furnished to SNF inpatients and patients in Medicare-participating End-Stage Renal Disease facilities or pay them under the CSW benefit if the services come under the respective participation requirements • Medicare may cover "incident to" services CSWs furnish for physicians, CPs, CNSs, NPs, PAs, or CNMs • Medicare does not cover services furnished "incident to" your personal professional services	The following payment guidelines apply: • Paid only on an assignment basis • Paid at 75% of the CPs Medicare PFS

Clinical Nurse Specialist (CNS)

Required Qualifications	Coverage	Payment
You must meet the following qualifications: • Registered Nurse (RN) currently licensed in the State where you practice and authorizes you to furnish CNS services according to State law • Doctor of Nursing Practice or Master's degree in a defined clinical nursing area from an accredited educational institution • Certified as a CNS by a recognized national certifying body with established CNS standards	The following coverage criteria apply: • Legally authorized to practice medicine in the State where you furnish services • Medicare does not statutorily preclude the services, and they are reasonable and necessary • Medicare considers the services physicians' services if furnished by an MD or DO • You furnish the services with a physician • Medicare may cover assistant-at-surgery services you furnish • You may personally furnish diagnostic psychological and neuropsychological tests with a physician as required under the CNS benefit and as permitted under State law • Medicare may cover "incident to" services and supplies	The following payment guidelines apply: • Paid only on an assignment basis • Paid at 85% of the amount a physician gets under the Medicare PFS • Medicare directly pays you for assistant-at-surgery services at 85% of 16% of the amount a physician gets under the Medicare PFS for assistant-at-surgery services

Nurse Practitioner (NP)

Required Qualifications	Coverage	Payment

You must meet the following qualifications:
• RN licensed and authorized by the State where you furnish NP services according to State law:
  ○ Got Medicare NP billing privileges for the first time since January 1, 2003, and:
  ▪ Are NP-certified by a recognized national certifying body with established NP standards
  ▪ Master's degree in nursing or a Doctor of Nursing Practice Doctoral degree
  ○ Got Medicare NP billing privileges for the first time before January 1, 2003, and meets the certification requirements described
  ○ Got Medicare NP billing privileges for the first time before January 1, 2001
	The following coverage criteria apply:
	• Legally authorized to practice medicine in the State where you furnish services
	• Medicare does not statutorily preclude the services, and they are reasonable and necessary
	• Medicare considers the services physicians' services if furnished by an MD or DO
	• Services are furnished with a physician
	• Medicare may cover assistant-at-surgery services you furnish
	• You may personally furnish diagnostic psychological and neuropsychological tests with a physician as required under the NP benefit and as permitted under State law
	• Medicare may cover "incident to" services and supplies
		The following payment guidelines apply:
		• Paid only on an assignment basis
		• Paid at 85% of the amount a physician gets under the Medicare PFS
		• Paid directly to you for assistant-at-surgery services at 85% of 16% of the amount a physician gets under the Medicare PFS for assistant-at-surgery services

Physician Assistant (PA)

Required Qualifications	Coverage	Payment

You must meet the following qualifications:
• Licensed by the State where you practice and one of the following criteria:
  ◦ Graduated from a PA educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs, and the Committee on Allied Health Education and Accreditation)
  ◦ Passed the national certification examination administered by the National Commission on Certification of Physician Assistants
	The following coverage criteria apply:
	• Legally authorized to practice medicine in the State where you furnish services
	• Medicare does not statutorily preclude the services, and they are reasonable and necessary
	• Medicare considers the services physicians' services if furnished by an MD or DO
	• Services are furnished by an individual who meets all PA qualifications
	• You furnish services under the general supervision of an MD or DO
	• The physician supervisor or designee need not be physically present when a service is furnished unless State law or regulations require otherwise
	• Medicare may cover assistant-at-surgery services you furnish
	• You may personally furnish diagnostic psychological and neuropsychological tests under the general supervision of a physician as required under the PA benefit and as permitted under State law
	• Medicare may cover "incident to" services and supplies
		The following payment guidelines apply:
		• Paid only on an assignment basis
		• Paid only to your:
		  ◦ Qualified employer eligible to enroll in the Medicare Program under existing provider/supplier categories
		  ◦ Contractor
		• Paid at 85% of the amount a physician gets under the Medicare PFS
		• Paid to your employer or contractor for assistant-at-surgery services at 85% of 16% of the amount a physician gets under the Medicare PFS for assistant-at-surgery services

Certified Nurse-Midwife (CNM)

Required Qualifications	Coverage	Payment
You must meet the following qualifications: • RN legally authorized to practice as a nurse-midwife in the State where you furnish services • Successfully completed a nurse-midwives program of study and clinical experience accredited by an accrediting body approved by the U.S. Department of Education • Certified as a nurse-midwife by the American College of Nurse-Midwives or the American College of Nurse-Midwives Certification Council	The following coverage criteria apply: • Legally authorized to practice medicine in the State where you furnish services • Medicare does not statutorily preclude the services, and they are reasonable and necessary • Medicare considers the services physicians' services if furnished by an MD or DO • You furnished services without physician supervision and without association with a physician or other health care provider, unless otherwise required under State law • You may personally furnish diagnostic psychological and neuropsychological tests without physician supervision or oversight as authorized by the CNM benefit and permitted under State law • Medicare may cover "incident to" services and supplies	The following payment guidelines apply: • Paid only on an assignment basis • Paid at 80% of the lesser of the actual charge or 100% of the amount a physician gets under the Medicare PFS

Independently Practicing Psychologist (IPP)

Required Qualifications	Coverage	Payment

You must meet the following qualifications:
• Psychologist who is not a CP
• Meets one of the following criteria:
  ◦ Practices independently of an institution, agency, or physician's office and is licensed or certified to practice psychology in the State or jurisdiction where you furnish the services
  ◦ Practicing psychologist who furnishes services in a jurisdiction that does not issue licenses
	The following coverage criteria apply:
	• Medicare does not statutorily preclude the services, and they are reasonable and necessary
	• Furnish services on your own responsibility, free of the administrative and professional control of an employer (for example, a physician, an institution, or an agency)
	• You treat your own patients
	• When you practice in an office that is in an institution:
	  ◦ The office is confined to a separately identified part of the facility used solely as an office and cannot be construed as extending throughout the entire institution
	  ◦ You conduct a private practice (to patients outside the institution as well as institutional patients)
	• You may furnish diagnostic psychological and neuropsychological tests when a physician orders such tests
	• You have the right to bill directly and collect and retain the fee for your services
		The following payment guidelines apply:
		• Diagnostic psychological and neuropsychological tests are not subject to assignment; however, you must include the name and address of the physician ordering the tests on the claim form
		• Paid at 100% for assigned services under the Medicare PFS

"Incident to" Provision

A physician, CP, CNS, NP, PA, or CNM may furnish outpatient psychiatric services and supplies "incident to" their professional services. Medicare pays under the "Incident to" Provision when the services and supplies comply with State law and meet all the following requirements:

- The services and supplies must be integral to the patient's normal course of treatment where the physician or other listed NPP has personally furnished an initial service and remains actively involved in the course of treatment.
- The practitioner commonly furnishes the services and supplies without charge (included in the physician's or other listed NPP's bill).
- The services and supplies are an expense to the physician or other listed NPP.
- The services and supplies are commonly offered in the physician's or other listed NPP's office or clinic.
- The physician or other listed NPP furnishes direct supervision, which means they are present in the office suite and immediately available if needed.

Medicare may cover CPs, CSWs, CNSs, NPs, PAs, and CNMs, services and supplies as an "incident to" the professional services of a physician or other specified NPP, the same as an MD or DO.

Commonly Used CPT Codes

There are thousands of CPT codes. Using the correct CPT code specifies the mental health service(s) you furnished to patients and is essential to correct billing. The most commonly used psychiatric and therapeutic codes include 90791, 90792, 90832, 90834, 90837, 90846, 90847, 90853, and 90839.

Table 1. Eligible Professionals Commonly Used CPT Codes

Description	CPT Code
Interactive complexity add-on (for psychotherapy codes)	90785
Psychiatric or psychological intake interview without medical services	90791
Psychiatric intake interview with medical services	90792
Thirty minutes of individual psychotherapy	90832
Thirty minutes of individual psychotherapy performed with an E/M service	90833
Forty-five minutes of individual psychotherapy	90834
Forty-five minutes of individual psychotherapy performed with an E/M service	90836
Sixty minutes of individual psychotherapy	90837
Sixty minutes of individual psychotherapy performed with an E/M service	90838
Patient in crisis add-on—Sixty minutes	90839*

Table 1. Eligible Professionals Commonly Used CPT Codes (cont.)

Description	CPT Code
Patient in crisis add-on—Each additional 30 minutes	90840
Other psychotherapy procedures, such as Psychoanalysis	90845
Family psychotherapy without the patient present	90846
Family psychotherapy with the patient present	90847
Multiple-family group psychotherapy	90849*
Group psychotherapy	90853*
Electroconvulsive therapy (includes monitoring)	90870
Aphasia assessment	96105
Developmental Testing, Extended	96111*
Sixty minutes Neurobehavioral Status Exam (clinical assessment of thinking, reasoning, and judgment)	96116
Sixty minutes Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed	96130
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, each additional hour (List separately in addition to code for primary procedure)	96131
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, each additional hour (List separately in addition to code for primary procedure)	96132
Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, each additional hour (List separately in addition to code for primary procedure)	96133
Thirty minutes Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method	96136

Table 1. Eligible Professionals Commonly Used CPT Codes (cont.)

Description	CPT Code
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, each additional 30 minutes (List separately in addition to code for primary procedure)	96137
First thirty minutes Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method	96138
Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	96139
Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	96146
Fifteen minutes Health and Behavioral Assessment	96150*
Fifteen minutes Reassessment	96151*
Fifteen minutes Health & Behavior Intervention—Individual	96152*
Fifteen minutes Health & Behavior Intervention—Group	96153*
Fifteen minutes Health & Behavior Intervention—Family with Patient	96154*
Fifteen minutes Health & Behavior Intervention—Family without Patient	96155

* Mental Health code not approved for partial hospitalization program.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

The NCCI promotes national correct coding methods and gives national guidance on code pair edits that prevent billing certain services on the same day. For more information about the NCCI, refer to the National Correct Coding Initiative Edits webpage and the How to Use the Medicare National Correct Coding Initiative (NCCI) Tools booklet.

ASSIGNMENT

All Medicare-patient medically necessary services must be furnished by professionally qualified practitioners.

- If a psychiatrist is a Medicare participating physician who accepts assignment for their services, they must accept assigned payment for all Medicare-covered patient services.
- If a psychiatrist does not participate under Medicare, they can accept assignment on a case-by-case basis. However, if a non-participating physician does not accept assignment, they get 95 percent of the Medicare PFS amount.

- The services of CPs, CSWs, CNSs, NPs, PAs, and CNMs are always subject to assignment. Payment for their services is always made under assignment even if non-physician practitioners (NPPs) participate in the Medicare Program.
- Medicare does not require IPPs authorized to furnish only diagnostic psychological and neuropsychological tests to accept assigned payment for them. Medicare pays participating IPPs for these tests at 100 percent of the Medicare PFS amount and pays non-participating IPPs at 95 percent.
- Assignment means the provider or supplier:
  - Gets the Medicare-allowed amount as payment-in-full for their services.
  - May not bill or collect from the patient any amount other than unmet copayments, deductibles, and/or coinsurance.

OUTPATIENT PSYCHIATRIC HOSPITAL SERVICES

Outpatient psychiatric hospital services and supplies must be:

- Medically necessary for diagnostic study or the patient's condition is reasonably expected to improve (see the Same Day Billing Guidelines section for more information about medically necessary services and supplies)
- Given under an individualized written plan of care (POC) that states:
  - The type, amount, frequency, and duration of services
  - The diagnosis
  - Expected goals (except when you only furnish a few brief services)
- Supervised and periodically evaluated by a physician who:
  - Prescribes the services
  - Determines the extent the patient reached their treatment goals and whether the POC should change
  - Furnishes supervision and direction to the therapists involved in the patient's treatment
  - Documents their involvement in the patient's medical record
- For diagnostic study or, at a minimum, designed to reduce or control the patient's psychiatric symptoms to prevent a relapse or hospitalization **and** improve or maintain their level of functioning

Generally, Medicare **covers** the following outpatient hospital psychiatric treatment services:

- Medically necessary diagnostic services for diagnosing individuals when extended or direct observation is necessary to determine functioning and interactions, identify problem areas, and prepare a POC
- Individual and group psychotherapy with physicians, CPs, CSWs, or other eligible providers authorized or licensed by the State where they furnish services
- Social workers, psychiatric nurses, and other staff trained to work with psychiatric patients

- Occupational therapy services, as part of a PHP, that:
  - Require qualified occupational therapist skills
  - Are furnished by, or under the supervision of, a qualified occupational therapist
  - Are included in the patient's POC
- Activity therapies, as part of a PHP, that are:
  - Individualized and essential for treating the patient's diagnosed condition and progressing toward treatment goals
  - Clearly supported in the POC and show the need for each therapy (cannot be primarily recreational or diversionary)
- Family counseling services while treating the individual's condition
- Patient training and education when they are closely and clearly related to the care and treatment of the individual's diagnosed psychiatric condition
- Drugs and biologicals for therapeutic purposes and the patient cannot self-administer them

The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better patient health and care. Medicare can furnish CCM services to patients with multiple chronic conditions. As one example, patients with dementia typically have multiple chronic conditions that could involve both physical and behavioral health issues (for example, depression). For more information on CCM and important CPT codes, refer to the Chronic Care Management Services booklet.

Generally, Medicare **does not** cover the following outpatient hospital services:

- Meals and transportation
- Activity therapies, group activities, or other primarily recreational or diversionary services and programs
- Psychosocial programs (Medicare covers psychosocial components of an outpatient program not primarily for social or recreational purposes)
- Vocational training related **only** to specific employment opportunities

Partial Hospitalization Program (PHP)

PHPs are distinct and structured programs that provide intensive outpatient psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services. Medicare covers ambulatory PHPs and Community Mental Health Centers.

The patient may pay a percentage of the Medicare-approved amount for each service they get from a doctor or certain other qualified mental health professionals, if that health care professional accepts assignment. The patient may also pay coinsurance for each day of PHP services furnished in a hospital outpatient setting or CMHC.

PHPs offer psychiatric treatment less than 24-hours a day to patients who are:

- Discharged from inpatient hospital treatment and the PHP replaces continued inpatient treatment
- At reasonable risk of needing inpatient hospitalization without partial hospitalization

The PHP must meet the following program and patient criteria (42 Code of Federal Regulations (CFR) § 410.43) guidelines:

- Active treatment that includes an individual plan of care (POC) with coordinated services designed for the patient's needs
- POC treatment includes a multi-disciplinary team approach to care directed by a physician who certifies the patient's need for partial hospitalization and a minimum of 20 hours per week of therapeutic services
- Treatment goals should be:
  - Measurable
  - Functional
  - Time-framed
  - Medically necessary
  - Directly related to the admission reason
- The patient requires comprehensive, highly structured, and scheduled multi-modal treatment that requires medical supervision and coordination under an individualized POC because of a mental disorder that severely interferes with multiple areas of daily life (social, vocational, activities of daily living [ADL]/instrumental ADLs, and/or educational functioning)
- The patient can cognitively and emotionally participate in the active treatment process and can tolerate the intensity of it

Medicare **does not** cover the following under PHP services:

- Hospital inpatient services
- Meals, self-administered medications, transportation
- Support groups for people to talk and socialize (this is different than group psychotherapy, which is covered)
- Testing or training for job skills not part of the mental health treatment

Community Mental Health Center (CMHC)

CMHCs furnish partial hospitalization services under Medicare Part B and are subject to the Outpatient Prospective Payment System (OPPS). Medicare-authorized CMHCs must meet the following program and patient criteria (42 CFR § 485.900) guidelines:

- Meet appropriate State CMHC licensing or certification where located
- Furnish:
  - Outpatient services including specialized outpatient services for children, older adults, individuals who are chronically mentally ill, and residents of its mental health service area discharged from inpatient treatment at a mental health facility
  - Twenty-four-hour emergency care services with access to a clinician and appropriate disposition with follow-up documentation of the emergency in the patient's CMHC medical record
  - Day treatment, partial hospitalization services, or psychosocial rehabilitation services with structured daily treatment plans that vary in intensity, frequency, and duration based on the patient's needs
  - Provide at least 40 percent of its services to individuals who are ineligible for benefits under Title XVIII of the Social Security Act
  - Clinical evaluation of candidates for admission to a State mental health facility by clinical personnel and authorized under State law, except for those furnished by a 24-hour facility; a CMHC operating in a State that, by law prevents it from giving these services, may contract with an approved entity (as determined by the Secretary of the U.S. Department of Health & Human Services)

42 CFR § 419.43(7) states on or after January 1, 2017, CMHC outlier payments are subject to a cap, applied at the individual CMHC level, so each CMHC's total outlier payments for the calendar year do not exceed 8 percent of that CMHC's total per diem payments for the calendar year. Total per diem payments include total Medicare per diem payments plus the total patient's share of those per diem payments. For more information, refer to the Inpatient Psychiatric Facility Prospective Payment System booklet.

A CMHC is an originating site for telehealth services. For more information about telehealth services and important coding information, refer to the Telehealth Services booklet.

Behavioral Health Integration Services

Integrating behavioral health care with primary care ("behavioral health integration" or "BHI") is an effective strategy for improving outcomes for the millions of Americans with mental or behavioral health conditions. Effective January 1, 2017, Medicare separately pays physicians and NPPs for furnishing BHI services to patients over a calendar month. For more information on BHI, which includes psychiatric collaborative care services and important coding information, refer to the Behavioral Health Integration Services booklet.

INPATIENT PSYCHIATRIC FACILITY SERVICES

Inpatient Psychiatric Facilities (IPFs) include freestanding psychiatric hospitals and certified psychiatric units in acute care hospitals or critical access hospitals (CAHs). IPFs furnish routine hospital and psychiatric services to diagnose and treat patients with mental disorders.

Medicare pays for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) when the institution meets Inpatient Psychiatric Hospital Services Regulations.

Updated hospital inpatient rights and discharge planning conditions of participations for short-term acute-care, rehabilitation, psychiatric, children's, cancer, and critical access hospitals are in effect.

42 CFR § 482.43 contains the current discharge planning conditions of participation requirements.

Medical Records Requirements

42 CFR § 482.61 states the IPF medical records must show the level and intensity of treatment for each patient a physician or NPP admits to the hospital, among other requirements.

42 CFR § 482.13 allows patients to access their medical records when requested verbally or in writing, and the hospital must quickly seek to meet the patient's request.

The medical records checklist reminds clinicians and staff of required documentation.

Medical Records Checklist

Develop Assessment and Diagnostic Data

Medical Records Content	Check if Yes
• Patient identification data including inpatient legal status	
• History of findings and a treatment plan for the incoming patient	
• Provisional or admitting diagnosis for every inpatient including intercurrent disease diagnoses and psychiatric diagnoses	
• Admission reasons clearly documented by inpatient and/or others significantly involved	
• Social service records must include:	
◦ Inpatient, family members, and others' interviews	
◦ Home plans assessment	
◦ Family attitudes	
◦ Community resources	
◦ Contacts	
◦ Social history	
◦ If indicated, a completed and recorded neurological exam, completed during the admission physical	

Psychiatric Evaluation

Medical Records Content	Check if Yes
• Completed within 60 hours of admission	
• Medical history	
• Record of mental status	
• Illness onset noted and circumstances leading to admission	
• Attitudes and behavior described	
• Estimated intellectual and memory functioning and orientation	
• Inpatient inventory of assets, must be descriptive and not interpretive	

Comprehensive Written Treatment Plan

Medical Records Content	Check if Yes
• An Individual plan based on inpatient strengths and disabilities	
• A substantiated diagnosis	
• Short- and long-term goals	
• Specific treatment modalities used	
• Responsibilities of each treatment team member	
• Adequate documentation justifying the diagnosis, treatment, and rehabilitation activities completed	
• Documented inpatient treatment to assure inclusion of all active therapeutic efforts	

Recorded Progress

Medical Records Content	Check if Yes
• By the physician(s), psychologist(s) or other licensed independent practitioner(s)	
• Others significantly involved in active treatment modalities, when appropriate	
• Determine progress note frequency by the inpatient's condition less than weekly during the first two months and at least once per month thereafter	
• Progress notes must have revision recommendations in the treatment plan, when necessary	
• Progress notes must include a precise patient assessment of treatment plan progress	

Discharge Plan

Medical Records Content	Check if Yes
• Discharge Summary	
• Recap of patient's hospital stay	
• Recommended patient follow-up and aftercare	
• Patient condition summary at discharge	

*Discharge Planning Evaluation, Plan, and Summary

Medical Records Content	Check if Yes
• Does the hospital have a discharge planning process that applies to all hospital patients?	
• Did you identify, early in the patient's hospitalization, whether they were likely to suffer adverse health consequences if discharged without adequate discharge planning?	
◦ If yes, did you complete a discharge planning evaluation for them or was one requested by the patient/representative/physician?	
• Was the plan developed or supervised by an RN, social worker, or other appropriately qualified staff member?	
• Did the evaluation include patient need for post-hospital services and their capacity for self-care or the possibility of returning to their pre-hospital environment?	
• Was the planning evaluation timely to allow appropriate post-hospital arrangements?	
• Is the discharge planning evaluation in the patient's medical record including documentation of the interaction relaying the results of the evaluation to the patient/their representative?	

*Standard Discharge Plan

Medical Records Content	Check if Yes
• Did an RN, social worker, or other appropriately qualified staff member develop or supervise the development of the discharge plan if indicated in the evaluation?	
• If the evaluation showed no finding for a discharge plan, did the patient's physician request one?	
• Did the hospital reassess the patient's discharge plan if factors affecting the patient's continuing care needs developed?	
• Did the hospital arrange to implement the patient's discharge plan?	
• Did the patient/family/interested persons get counseling to prepare them for post-hospital care?	
• Did the hospital include a discharge plan list of Medicare Program Home Health Agencies (HHAs) (HHAs must request that the hospital list their service when available) and Skilled Nursing Facilities (SNFs) serving that geographic area where the patient lives or in the case of a SNF, in the requested geographic area?	
◦ Did you only present the list to the patient if they needed HH or post-hospital extended care services as indicated in the discharge planning evaluation?	
◦ If the patient was enrolled in a managed care organization, did the hospital indicate those services contracted with the managed care organizations?	
◦ Did you document that the list was presented to the patient in the medical record?	
• Did the hospital inform the patient/family of their freedom to choose among participating Medicare providers' post-hospital care services and respect the patient's/family's preference (the hospital must not specify or limit qualified providers available)?	
• Did the hospital disclose any financial interest it may have in the HHA or SNF?	

*Transfer or Referral

Medical Records Content	Check if Yes
• If you transferred or referred a patient, did you give the medical information to appropriate facilities, agencies, or outpatient services for follow-up or ancillary care?	

* Identifies the newer discharge planning conditions of participation.

Coverage Period

Medicare covers patients treated for psychiatric conditions in specialty facilities for 90 days per illness with a 60-day lifetime reserve and for 190 days of care in freestanding psychiatric hospitals (this 190-day limit does not apply to certified psychiatric units). Once a patient uses 190 days of psychiatric hospital care, they have no further benefits of that type.

Under the IPF PPS, Federal per diem rates include inpatient operating and capital-related costs (including routine and ancillary services). CMS determines them by:

- Geographic factors
- Patient characteristics
- Facility characteristics

IPFs get additional payments for:

- Patients treated in IPFs with a qualifying emergency department
- The number of ECT treatments furnished
- Outlier cases (cases with extraordinarily high costs)

For more information on how Medicare covers IPFs, refer to the Medicare Benefit Policy Manual, Chapter 2.

SAME DAY BILLING GUIDELINES

Integrating the following mental health and substance use disorder services is an approach to health care that better addresses the needs of all patients, whether they get care in a traditional primary care setting or a specialty mental or substance use disorder health care setting. Services include:

- Mental health care services (Medicare includes substance abuse treatment)
- Alcohol and/or substance (other than tobacco) abuse structured assessment, and intervention services (SBIRT services) billed under HCPCS codes G0396 (Alcohol and/or substance [other than tobacco] abuse structured assessment [e.g., audit, dast], and brief intervention 15 to 30 minutes) and G0397 (Alcohol and/or substance [other than tobacco] abuse structured assessment [e.g., audit, dast], and intervention, greater than 30 minutes)
- Primary health care services

Medicare Part B pays for reasonable and necessary integrated health care services when furnished on the same day, to the same patient, by the same or different professionals whether the professionals are in the same or different locations.

The Eligible Professionals section lists the providers eligible under Part B to furnish diagnostic and/or therapeutic treatment for mental, psychoneurotic, and personality disorders as well as Medicare SBIRT services as allowed under State law.

Generally, Medicare covers medically necessary and reasonable services or supplies to treat the patient's overall diagnosis and condition or improve a malformed body member. Services must meet the standards of good medical practice for diagnosis, direct care, and treatment of the patient's medical condition, and not mainly the convenience of the patient, provider, or supplier.

Services must also meet specific medical necessity criteria defined by National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). For more information, refer to the Medicare Coverage Determination Process webpage.

For every service billed, indicate the specific sign, symptom, or patient complaint indicating the service need. Although a service or test may be considered good medical practice, Medicare does not pay for services without patient symptoms, complaints, or specific documentation.

Medicare also pays for multiple mental health services furnished to the same patient on the same day. However, Medicare does not pay for inappropriate and/or duplicate services on the same day. If you have questions about local or national policies that may prevent you from billing for certain services on the same day your MAC may have more information: http://go.cms.gov/MAC-website-list.

RESOURCES

Table 2. Mental Health Services Resources

Resource	Website
CDC Guideline for Prescribing Opioids for Chronic Pain	CDC.gov/drugoverdose/prescribing/guideline.html
CMS Opioid Treatment Programs (OTPs)	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Index
FY 2020 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2019 (FY 2020) Final Rule	FederalRegister.gov/d/2019-16370
Inpatient Psychiatric Facility Prospective Payment System	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243666
Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care Final Rule	FederalRegister.gov/d/2019-20732

Table 2. Mental Health Services Resources (cont.)

Resource	Website
Medicare Benefit Policy Manual, Chapters 2, 6, and 15	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673
Medicare Claims Processing Manual, Chapters 3 and 4	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912
Mental Health Screening Tools	Integration.samhsa.gov/clinical-practice/screening-tools
Patient Quality of Care Complaints through the Patient and Beneficiary Family Centered Care Quality Improvement Organization (BFCC/QIO)	CMS.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index
Substance Abuse and Mental Health Services Administration (SAMHSA)	SAMHSA.gov
SAMHSA OTP Directory	Dpt2.samhsa.gov/treatment/directory.aspx

Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
42 Code of Federal Regulations (CFR) § 410.43	https://www.ecfr.gov/cgi-bin/text-idx?SID=27c3e1d4ab8c77569ec28005e2ede3b2&mc=true&node=pt42.2.410&rgn=div5#se42.2.410_143
42 CFR § 419.43(7)	https://www.ecfr.gov/cgi-bin/text-idx?SID=bd46a41ae1decbbd6b854f23cb05e131&mc=true&node=pt42.3.419&rgn=div5#se42.3.419_143
42 CFR § 482.13	https://www.ecfr.gov/cgi-bin/text-idx?SID=9208cea0c8c962f0d158a8c199bcd582&mc=true&node=pt42.5.482&rgn=div5#se42.5.482_113
42 CFR § 482.43	https://www.ecfr.gov/cgi-bin/text-idx?SID=9208cea0c8c962f0d158a8c199bcd582&mc=true&node=pt42.5.482&rgn=div5#se42.5.482_143

Table 3. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
42 CFR § 482.61	https://www.ecfr.gov/cgi-bin/text-idx?SID=9208cea0c8c962f0d158a8c199bcd582&mc=true&node=pt42.5.482&rgn=div5#se42.5.482_161
42 CFR § 485.900	https://www.ecfr.gov/cgi-bin/text-idx?SID=7f53707231b85c988721afe79a0a7742&mc=true&node=pt42.5.485&rgn=div5#se42.5.485_1900
Annual Wellness Visit (AWV)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246474
Behavioral Health Integration Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909432
Chronic Care Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909188
Copayments, Deductibles, and/or Coinsurance	https://www.medicare.gov/your-medicare-costs
How to Use the Medicare National Correct Coding Initiative (NCCI) Tools	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243274
Initial Preventive Physical Examination (IPPE)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243320
Inpatient Psychiatric Facility Prospective Payment System	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243666
Inpatient Psychiatric Hospital Services Regulations Medicare Benefit Policy Manual, Chapter 2	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c02.pdf
Medicare Coverage Determination Process Webpage	https://www.cms.gov/Medicare/Coverage/DeterminationProcess/index
Medication-Assisted Treatment (MAT)	https://www.samhsa.gov/medication-assisted-treatment
National Correct Coding Initiative Edits Webpage	https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index

Table 3. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
SBIRT	https://www.integration.samhsa.gov/clinical-practice/sbirt
Telehealth Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243327
Title XVIII of the Social Security Act	https://www.ssa.gov/OP_Home/ssact/title18/1800.htm